Swain County Schools' Medication Administration Authorization Form

School: ____

This form must be completed fully in order for schools to administer the required medication. A new medication administration form must be completed at the beginning of each school year, for each medication, and each time there is a change in dosage or time of administration of a medication.

- Prescription medication must be in a container labeled by the pharmacist or prescriber.
- Over the counter (OTC) medication must be in the original, unopened container with the label intact.
- **A parent/guardian must bring the medication to school and check it in with office staff or school nurse.**
- The school nurse (RN) will call the prescriber, as allowed by HIPAA, if a question arises about the student and/or the student's medication.

Prescriber's Authorization

(To be completed by the health care provider)

Name of Student:____DOB______________________Grade_______________

Condition for which medication is being administered:____

Medication Name:____Dose:________________Route:______________

Time dose needed:____If PRN how frequent___________________________

If PRN for what symptoms:____

Relevant side effect: ☐None expected ☐Specify:____

Medication shall be administered from:________________________________to _______________________________________

Month/Day/Year Month/Day/Year

Self-Carry/Self-Administration of Emergency Medication Authorization/Approval

Student has demonstrated ability and understands the use of and may carry and self-administer asthma medication, diabetes medication, and/or medicine for anaphylactic reactions. Self-administration of medication must be approved by the school nurse according to policy. See back of form for student self-carry contract. Only medications that a student may self-carry and/or self-administer are emergency medications such as asthma inhalers, epinephrine auto-injectors, insulin, and glucagon.

Student is competent to carry and administer own medication Yes ☐ ☐ No (Prescriber to authorize)

Prescriber's Name/Title:______________________________________
Telephone:______________________Fax:______________________
Address:____
Prescriber's Signature:_______________________Date:____________

Prescriber's Address Stamp use here

Parent/Guardian Authorization

I/We request designated school personnel to administer the medication as prescribed by the above prescriber. I/We certify that I/we have legal authority to consent to medical treatment for the student named above including the administration of medication at school and the ability to self-carry if deemed appropriate by the prescribing provider. I/we understand that at the end of the school year, an adult must pick up the medication, otherwise it will be discarded. I/we release the school board and their agents and employees from all liability that may result from my child taking the prescribed medication. I/we authorize the school nurse to communicate with the health care provider as allowed by HIPPA.

Parent/Guardian Signature____Date:________________________

Home Phone:___________________________Cell Phone:__________________________________Work Phone:_______________________________

Order reviewed by School Nurse (RN)____

Signature Date

Contract for Self-Carried Medication

Student____

DOB____Grade__________________

School____

Prescriber's Name____Telephone__________________

Medication____

Medication is permitted in accordance with state laws and district policy. Both student's health care provider and parent/guardian must complete a Medication Authorization Form. Student's name must appear on the medications and devices.

Responsibilities of the Student

- I plan to keep my inhaler, epinephrine auto-injector, and/or diabetes medication/equipment with me at school
- I agree to use my inhaler, epinephrine auto-injector, and/or diabetes medication/equipment in a responsible manner in accordance with my licensed health care provider's orders.
- I will notify school staff (School Nurse, teacher, etc…) if I am having more difficulty than usual with my health condition
- I will not allow any other person to use my medication and/or equipment

Student's signature____Date____________________

1. ____ Emergency Action Plan complete and on file at school
2. ____ Parent/Guardian declined Emergency Action Plan for condition which medication is being administered
3. ____ Demonstrated correct use/administration of medication and/or equipment
4. ____ Verbalizes proper and prescribed timing for medication
5. ____ Agrees to carry medication and/or equipment and is located ______________________________
6. ____ Can describe own health condition well
7. ____ Keeps a second labeled container in office
8. ____ Student verbalizes that she/he will not share medication and/or equipment with others

School Nurse's signature____Date__________________

Comments: